Appendix A:

Site-Specific Measures

The Multnomah County Criminal Justice Diversion Program did not use any site-specific measurements.

Appendix B:

Program Logic Models/Charts, Manuals and Fidelity Instruments

To order a copy of the program logic model, contact Robbianne Cole at (503) 243-2436 or e-mail cole@npcresearch.com.

1/01 DRAFT Multisite Process Study Chart

PROGRAM Elements	Arizona	Connecticut	Hawaii		New York City	Lane Co., OR	Portland, OR	Pennsylvania	Memphis, TN
PROGRAM STRUCTURE									
Point of Diversion	Post-booking: 1.arraignment 2.post-sentencing	Post-booking: 1.arraignment	Post-booking: 1.arraignment		Post-booking/ Pre-conviction: 1.criminal court 2.post-indictment 3.p & p violators	Post-booking/Pre-conviction: 1.criminal court Post-booking/Post-conviction: 1.P&P violators in jeopardy of sanction, violation, or revocation	Pre-booking	Pre-booking: 1.no charges 2.charged	Pre-booking: 1.no charges
Lead Organization **Funded by**	Regional Behavioral Health Authority	CT Dept. of MH and Addiction Services	HHH (Private, non-profit)		NYC Department of Mental Health	Lane Co. Sheriff's Office	Multnomah Co. Behavioral Health	MCES (Private, not-for-profit organization)	Community Coalition of Memphis Police Dept., Alliance of Mentally Ill, University of TN, Regional Medical Center
	AZ Dept. of Behavioral Health Services	CT Dept. of MH and Addiction Services	State Dept. of Health		NYC Mental Health	SAMHSA enhancement, State Court, County	Multnomah Co. Behavioral Health, Medicaid, County	County MH	City of Memphis, Shelby Co., various federal funding, Medicaid, Medicare, additional private funding sources
Service Systems Involved in the Diversion	Criminal Justice and Mental Health Tucson: Pre-trial Services	Mental health (Diversion Staff) and Criminal Justice (Defense, Bail Commissioner, Sheriff, Prosecutor, Judge)	Criminal Justice (Prosecutor, Defense Attorney, Judge) and Mental Health (Diversion Staff)		Criminal Justice (DA, Defense, Judge) Mental Health (Diversion Staff)	Criminal Justice (Prosecutor, Defense, Judge), Sheriff's Office, Mental Health and Substance Abuse	Criminal Justice (Police), MH (Crisis Center Staff)	Criminal Justice (Police), MH (Crisis Center Staff, Diversion Staff)	Law enforcement, MH, Health

PROGRAM Elements	Arizona	Connecticut	Hawaii		New York City	Lane Co., OR	Portland, OR	Pennsylvania	Memphis, TN
a. Formal written Agreements	a. Yes	a. Yes	a. No		a.No	a. Yes	a. Yes	a. No	a. Yes
b. Shared funding	b. No	b. No	b. No		b. No	b. No	b. No	b. No	b. No
c. Diversion Information System (and who is included)	c. Yes; Behavioral Health and Co. Sheriff's Departments (data link from jail to MH rosters)	c. No	c. No; two databases shared between Criminal Justice and MH		c. No; arrest and charge data shared between Diversion program and CJ	c. Data link from MH to Diversion Staff	c. No	c. ?????	c. No
Scope of Diversion Program Services	Tucson: ??? Phoenix: ???	Identify, screen, assess, negotiation with CJ, broker services, community monitoring	Identify, screen, negotiation with CJ, broker services, community monitoring		Identify, screen, assess, negotiation with CJ, broker services, community monitoring, case management	Identify, screen, diagnostic/risk assessment, negotiation with CJ, broker services, case management, court liaison, court appearance	Police screening, crisis intervention, diagnostic assessment, triage, clinical services, referral, commitment/risk assessment	Police screening, crisis intervention, assessment, case management	Police screening, crisis intervention, diagnostic assessment, medical assessment, triage and referral, commitment/risk assessment
Staffing/hired by	Regional Behavioral Health Authority	Dept. of Mental Health and Addiction Services	HHH (not-for-profit agency)		DMH-contracted programs (MH and ATI)	Sheriff's Office	Portland Police Dept., Crisis Triage Center, Behavioral Health	Montgomery Co. Police Departments(???), MCES	Memphis Police Dept., Regional Medical Center, University of TN
a. Professional Training	a. Bachelor's Level; Supervisory CSW	a. Master's-Level Clinicians	a. None		a. case managers: M.A., CSW; supervisory: M.A., CSW	a. MA/MSW or QMHP	a. Law enforcement training, MD, RN, MA, CSW	a. Law enforcement training, RN, BA, MA	a.Commissioned officers, MD (psychiatry, general medicine), PhD (clinical psych), RN (psychiatric)
b. Scope of training	b. None	b. Co-Occurring Disorders, Local Diversion Model	b. None		b. MH, SA, CJ, Entitlements	b. MH, SA, CJ	b. MH, SA, CJ	b. MH, SA, CJ	b. CIT training

PROGRAM Elements	Arizona	Connecticut	Hawaii		New York City	Lane Co., OR	Portland, OR	Pennsylvania	Memphis, TN
					PROCEDURE				
Diversion Identification **a.Staff characteristics** **b.how is identified** **c.who is identified** **d. where are they identified**	a. MH Staff, Pre-Trial Services Staff, Prosecutor's Office, Public Defenders b. positive matches between arrest booking records and MH membership rosters c. individuals who are recipients of MH services and committed misdemeanant offenses d. jail booking facilities	a. Mental Health (Diversion Staff) and Criminal Justice (Defense, Bail Commissioner, Sheriff, Prosecutor, Judge) b. arraignment list screened for known MH clients, behavior/observation c. those with past system involvement or current symptoms d. court	a. CJ (OIS), MH (Diversion Staff) b. review of BHIS c. MH history d. court lock-up		Identification process. a.Jail MH staff, defense and DA, correctional staff, specialty drug and domestic violence court staff. b. history of tx and suicide questions; behavior/ observation c. those with recent treatment or medication or believed at risk; behavior d. jail intake, jail, court	a. Corrections officers, MH workers, Prosecutor, Defense Attorney, Release Officer, family members, (maybe Probation Officer) b. current symptoms, MH history c. people with history of mental illness or current diagnosis d. jail booking (or by P.O. in community)	a. CIT Police Officers b. interaction c. those thought to be at risk for dangerousness due to mental illness d. on the street	a. Police Officers, Diversion Staff b. behavior/observation, information system screening c. highly symptomatic people, those with past system involvement d. on the street, post-MCES commitment	a. CIT Police Officers b. interaction c. those thought to be at risk for dangerousness due to mental illness d. on the street
Screening protocol **a.who screens** **b. where are they screened**	Informal screening or review of client's treatment record a. jail diversion staff in consultation with case manager b. jail c. clients that the diversion team	Informal screening a. Diversion Staff, sometimes in consultation with treating clinician b. court c. clients that the diversion team deems likely to benefit from	a. CJ (OIS) b. brief screening c. those with history of mental illness and those showing current symptoms d. court		Structured interview re cj and medical, and mh and sa use/treatment, behavioral, arrest records, psychosocial a.diversion case management staff b.in jail and court diversion offices c. SPMI with legal charges of all	Initial standardized interview a. booking officers; review by MH diversion staff b. booking area of jail c. those with history of SPMI and co-occurring	Informal screening a. Police b. Street c. Those eligible under OR commitment statutes	None	Police Screening a.Police b.Street c. Those eligible under TN commitment statutes

PROGRAM Elements	Arizona	Connecticut	Hawaii		New York City	Lane Co., OR	Portland, OR	Pennsylvania	Memphis, TN
c.which clients are accepted	deems likely to benefit from diversion	diversion			misdemeanors, C and D felonies with B case-by-case.	substance abuse disorder, who are not significantly cognitively impaired and not an imminent risk of violence			
Separate Assessment **a.who assesses** **b. who is assessed** **c.where assessed**	Yes (Tucson only) a. Case manager b. Everyone who's diverted c. Clinic	Yes a. Diversion Staff b. Everyone who's diverted c. Court	No		Yes a.jail psychiatrist or paid forensic psychiatrist consultant b. Everyone who's diverted c. jail or court clinics	Yes a. Jail MH Staff and/or Psychiatrist b. Everyone who's diverted c. Jail	Yes a. Crisis Center Nurse b. Everyone who's diverted c. Crisis Triage Center	Yes a. MCES Staff (Crisis Staff and Psychiatrist) b. Everyone c. MCES	
Decision to Divert (decision maker) **a. Others involved** **b. Requires Client consent**	Prosecutor's Office a. Regional Behavioral Health Jail Liaison Staff, Providers of MH Services b. Yes	Judge a. Recommendations from Public Defender and Prosecutor , Bail Commissioner b. Yes	Judge a. Prosecutor, Defense Attorney b. Yes		Judge a. Must have Prosecutor agreement; informed by defense, diversion program and often independent psychiatrist b. Yes	Prosecutor or P.O. a. Must have consent of Diversion Staff, Defense Attorney b. Yes	Police a. No b. No	Police a. With recommendations from Diversion Staff b. No	
Legal Outcome of Criminal Charges for Successful Divertees	Dismissal of charges or Summary Probation	Deferred Prosecution, Dismissal of charges or Not Prosecuted or Probation with special conditions	Deferred Prosecution , dismissal, sentenced		?(reduced sentence, dismissal, deferred prosecution, sentenced	Deferred Prosecution, dismissal after one year	Never charged	No charges, reduced charges, charges dropped	

PROGRAM Elements	Arizona	Connecticut	Hawaii		New York City	Lane Co., OR	Portland, OR	Pennsylvania	Memphis, TN
Consequences for Failure to Comply (types of sanctions)	Charges re-instated only for those in deferred prosecution, all others no sanctions	Unless immediately dismissed or prosecution dropped, charges are re-instated, Otherwise no sanctions.	Return to normal adjudication.		__% of study participants __% of program participants no legal consequence, but may have difficulty with treatment reacceptance; __% of study participants and __% of Program participants are sanctioned: increase structure of treatment, brief jail staff, prison/re-sentenced	Return to court for normal adjudication	None	None	
Criminal Justice Monitoring **a.who monitors** **b. where (in court, in the community)** **c. what is monitored** **d. frequency of monitoring**	Yes (Only for deferred prosecution participants) a. ??? b. ??? c. ??? d. ??? e. ???	Yes, for those whose charges remain pending a. Diversion Program b. Treatment Program reports to Diversion c. Treatment involvement d. Report of change in status until case is disposed of. e. Until case is disposed of (2 weeks to 3 months)	None		Yes (Only for those in Brooklyn). Of those monitored: a.Diversion program reports to Judge b. community monitoring (client and program visits) c. drug use through urine testing; treatment participation, CJ activity d. one time per week provider contact, one time per week client if at home—one time month if in residence; approx. every six weeks to three months to court. e. 24 months for felons; 12 months for	Yes a. Jail Diversion Staff reports to Drug Court Judge b. In court c. Treatment participation and compliance, urinalysis, and CJ activity d. At least monthly e. 12 months in State Court, 3 months in Municipal Court.	None	None, unless charges are pending If monitored: a. Diversion program reports to police b. In inpatient settings c. Treatment compliance, motivation d. Report of change in status until release from inpatient e. Until release from inpatient	

PROGRAM Elements	Arizona	Connecticut	Hawaii		New York City	Lane Co., OR	Portland, OR	Pennsylvania	Memphis, TN
e.length of monitoring period					misdemeanors				
Diversion Program Follow-up a.length of time b. frequency	a. 4-6 months b. varies	None. All follow-up by linkage program.	a. ??? b. ???		All program participants are followed two years post jail release/post CJ contact. a.24 months b. weekly for two months and then quarterly for remaining two years unless leaves programs and then frequency increases	a. one year in State Court, 3 months in Municipal Court b. weekly contact with diversion staff, monthly contact with court	None	Some program participants are followed by a forensic case manager. a. ??? b. Weekly or at least once a month????	
LINKAGE SERVICE PATTERNS									
Scope of Interagency Linkages	Comprehensive Provider Network	Comprehensive Behavioral Health Services available through network	Comprehensive Behavioral Health Services		Comprehensive Behavioral Health Services, housing	Comprehensive Behavioral Health, CJ, Oregon Health Plan, some housing	Comprehensive Behavioral Health Services	Diversion team links some inpatients with comprehensive Behavioral Health Services	
a. Formal linkage agreements	a. Contracts	a. Contract between state agency and non-profits	a. Some contracts		a. No	a. Varies from Memorandums of Understanding to none	a. MOU's and contracts	a. No	

PROGRAM Elements	Arizona	Connecticut	Hawaii		New York City	Lane Co., OR	Portland, OR	Pennsylvania	Memphis, TN
b. Shared funding **c. Information**	b. No shared funding c. Formal service and client reporting requirements	b. Non-profits are grantees of state. c. Client-specific information reported	b. No shared funding c. Client-specific information reported		b. No shared funding c. No formal information system; client treatment progress periodically reported	b. None c. Weekly comprehensive staffings	b. None c. No formal information systems; client treatment progress reported to state system	b. No shared funding c. No formal information system	
Systems Involved in Diversion Linkage Process	MH, SA, CJ	MH, SA, CJ	MH, SA, CJ		MH, SA, CJ, HRA, DHS	MH, SA, CJ	MH, SA, CJ	MH, SA, CJ???	
Range of Linked Services **a. minimum linkage requirement for diversion**	Comprehensive behavioral health services a. None	Tx (out-pt, in-pt, residential: SA, MH, MICA); medication, medical, housing, vocational a. Program referral	Tx (out-pt, in-pt, residential: SA, MH, MICA); medication, medical, housing, vocational, education, family services, entitlements a. Program referral		Tx (out-pt, in-pt, residential: SA, MH, MICA); medication, medical, housing, vocational, education, family services, entitlements a. medication, entitlement application, shelter, treatment	Tx (out-pt, in-pt, residential: SA, MH, MICA); medication, medical, housing, entitlements a. MH/SA treatment	Tx (out-pt, in-pt, residential: SA, MH, MICA); medication, medical, housing, vocational, education, family services, entitlements a. None	Inpatient tx to other Tx (out-pt, other in-pt, residential: SA, MH, MICA); medication, medical, housing, vocational, education, family services, entitlements a. None	

Appendix C:

Published and Unpublished Articles Resulting from the Study

A copy of the following article was included in the Final Report: *A specialized crisis response site as a core element of police-based diversion programs.* Steadman, H.J, Stainbrook, K.A., Griffin, P., Draine, J., Dupont, R., Horey, C. *Psychiatric Services. Vol 52*(2), American Psychiatric Assn. February 2001, 219–222.

To order this article, contact Robbianne Cole at (503) 243-2436 or e-mail cole@npcresearch.com.

Appendix D:

Case Examples

Case Examples

Case Number One

A 36-year-old mother of two was diverted from jail and transferred to the Crisis Triage Center (CTC). The woman had a clinical diagnosis of bipolar disorder and was identified as having a substance use disorder as part of the interview process using the Michigan Alcohol Screening Test (MAST). The police were called to her home to investigate a domestic dispute. Upon arriving the police were informed that the woman had assaulted her husband with a frying pan. The police put the woman in custody. The police learned from the husband that the woman suffers from bipolar disorder and that she had not been taking her medication due to the fact that she was breast-feeding her 9-month-old child. The husband informed the police that the doctor had ordered the woman not to take her medication while breast-feeding because it would adversely affect her infant daughter.

The police had two options: either arrest the woman and charge her with threatening/menacing or take her into protective custody and transport her to the CTC. The police decided to take her to the mental health emergency room for evaluation. The husband decided not to press charges.

Upon arrival at the CTC the woman was put into a secure room for her protection and given a thorough psychiatric evaluation. It was recommended that she enter into respite care to give her a few days to be evaluated and allow her to stabilize emotionally away from home. The woman stayed in respite care for three days. During this time she was counseled by the case manager and given access to follow up services. The staff discussed options with her about re-starting her medication. She decided to take her medication because it made her feel stable and confident to make decisions that were once clouded. One of her fears was the effect of her medications on her baby who was still breast-feeding, but after stabilizing and discussing the benefits of being on medication, she felt that it was a better decision to take the medication and start her child on infant formula.

The woman was released from respite care with a follow-up referral to family counseling. At her 3-month interview, the woman explained that she and her husband were working on their marital issues with a counselor. She had been doing very well emotionally on her medication and was referred to counseling as a result of being diverted.

At her 12-month interview she was still in counseling and though difficult at times her marriage was improving. She was also attending a support group for people with parents that are/were alcoholics, and this was a tremendous support for her. She reported that her medication was still helping her emotionally and that there seemed to be fewer side effects now. She also reported that although the incident with her husband was extremely embarrassing it created a positive shift in behavior for her. She was thankful that she was diverted to the CTC as opposed to being arrested and charged with a crime.

Case Number Two

A 32-year-old white female, diagnosed with bipolar disorder and substance abuse disorders was taken into custody for reckless driving. The police officers dispatched had completed the crisis intervention team (CIT) training and were trained on identifying people in mental health crisis and they decided to take the woman to the CTC were she could be given a mental health evaluation. The woman was evaluated by a team of mental health professionals and hospitalized for 5 days. During hospitalization the woman was stabilized on her medication. The woman had recently lost her job and stopped taking her medication. The caseworker on the study helped the client get in touch with a psychiatrist that could monitor her medication and eventually would become her full-time psychiatrist.

At the time of the 3-month interview, the woman stated that she had been seeing her psychiatrist regularly and that the medication was helping tremendously. The client had been contacted by the caseworker about possible services that she could receive. The caseworker gave referrals to counseling services and gave the client her card in case there was an emergency. The client obtained a job in this time period.

At the 12-month interview the client was still being followed by the caseworker. The client reported that she was now the manager were she worked and that things were going well for her at this point in time. The client also stated that she had been contacted regularly throughout the year by the caseworker. The client stated that she liked having the support in a time of need. She said that the year had been a difficult one at first, but once connected to a qualified psychiatrist and stabilized on medications the year had been a beneficial one. The client also stated that the time she had been arrested was her only interaction with the police ever. She was glad they had been trained to recognize a mental health emergency and did not take her jail were she might have obtained a police record. She said that the caseworker had done an excellent job connecting her to the one thing she needed, which was a good psychiatrist who could put her on stabilizing medications.

Appendix E:

Statement Regarding Continued JD Steering Committee Collaboration

Appendix F:

Tables & Figures

Table 1: Recruitment and Retention

	TOTAL N		Recuitment/ Retention Rate
	Treatment	Comparison	
Intake interview	72	133	77%
3-month follow-up	54	121	85%
12-month follow-up	56	116	84%
Completed sets of intake, 3-month and 12-month interviews	53	106	

Table 2. Treatment history baseline differences between diversion and jail groups

	Total Sample (N = 205)	**Diversion** (n = 73)	**Jail** (n = 132)
Treatment[1]			
Mental Health			
Inpatient	17%	18%	16%
Emergency Services	29%	22%	33%
Outpatient	41%	38%	42%
Substance Abuse			
Inpatient	12%	7%	14%
Emergency Services	21%	10%	27%*
Outpatient	29%	19%	35%*

[1] Pearson Chi-Square, significance criterion p <. 05
* Significant difference

Table 3. Demographic baseline differences between diverted and jail groups

	Total Sample (N = 205)	**Diversion** (n = 73)	**Jail** (n = 132)
Gender[1]			
Female	31%	26%	33%
Male	69%	74%	67%
Race/Ethnicity[2]			
American Indian/Alaskan Native	6%	11%	4%
Asian	1%	3%	1%
Native Hawaiian or Other Pacific Islander	1%	3%	0%
Black or African American	17%	14%	18%
Hispanic or Latino	6%	3%	8%
White	56%	59%	54%
Mixed Race	13%	7%	16%
Other	0.5%	1%	0%
Age[3]	35.5	35.4	35.5
Education[3] **highest grade completed**	**12th**	**12th**	**11th ***

[1] Pearson Chi-Square, significance criterion p <. 05
[2] Configural Frequency Analysis (test for dependence between categorical variables), significance criterion standardized residual > 2.0 or < -2.0
[3] Independent Samples T-Test, significance criterion p < .05
*** Significant difference in bold**

Table 4. Descriptives for time spent in institutionalized care for the diversion and jail groups at the 3- and 12-month interviews.

3-Month Interview			**12-Month Interview***		
	Diversion	Jail		Diversion	Jail
1 day or less	39%	12%	Mean	58.1	109.6
2–6 days	17%	7%	SD	85.15	109.02
1–4 weeks	26%	37%		* average number of days	
1–3 months	18%	44%			

Table 5. Intake criteria baseline differences between diverted and jail groups

	Total Sample (N = 205)	**Diversion** (n = 73)	**Jail** (n = 132)
Arrest Charge[1]			
Crimes Against Person	20%	47%*	5%*
Drug Crimes	15%	4%*	21%
Property Crimes	9%	1%*	14%
Procedural Violations	37%	16%*	48%*
Other Crimes	19%	32%*	12%
Jail Nights[2] **(1 year prior to intake)**	**60.4**	**37.6**	**72.9***
Primary Diagnosis[1]			
Schizophrenia	17%	18%	16%
Major Depressive Disorder	37%	29%	42%
Bipolar Disorder	46%	53%	42%
CSI[2]	**46.0**	**50.3**	**43.5***
Substance Use Symptoms[2]			
MAST	**24.7**	**18.6**	**28.1***
Indication of Alcohol Abuse Problem	92%	92%	92%
DAST	**11.2**	**7.5**	**13.3***
Indication of Substance Abuse Problem	82%	62%	92%*
Alcohol Use[2]			
Average Daily Servings	4.9	3.5	5.6*
Average Days Drinking per Month	7.0	5.3	7.9*
Binge Drinking[†]	36%	32%	39%
Drug Use[2]			
Average Days Using	12	6.3	15.1*
Types of Drugs Used[3]			
Marijuana	47%	45%	48%
Cocaine/Crack	41%	16%	55%*
Sedatives	14%	4%	20%*
Stimulants	38%	33%	40%
Opiates	5%	0%	8%*
Psychedelics	7%	7%	8%
Inhalants	3%	4%	3%

[1] Configural Frequency Analysis (test for dependence between categorical variables), significance criterion standardized residual > 2.0 or < -2.0
[2] Independent Samples T-Test, significance criterion $p < .05$
[3] Pearson Chi-Square, significance criterion $p <. 05$
* Significant difference in bold
[†] > 5 drinks for men and > 4 drinks for women

Figure 1. Differences between diversion and jail groups in average number of days per month that drugs were used at the 3- and 12-month interviews.

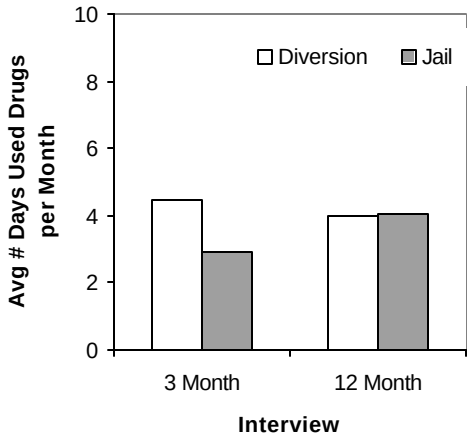


Figure 2. Differences between diversion and jail groups in percentage of participants who reported binge drinking at the 3- and 12-month interviews.

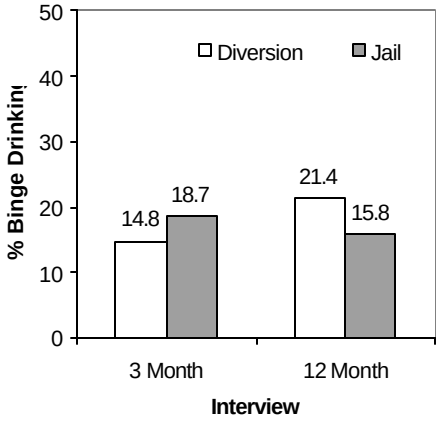


Figure 3. Differences between diversion and jail groups in average number of days per month that drugs were used at the 3- and 12-month interviews.

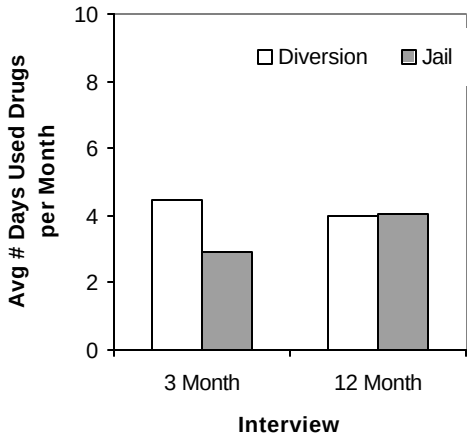


Figure 4. Differences between diversion and jail groups in CSI scores at 3- and 12-month interviews.

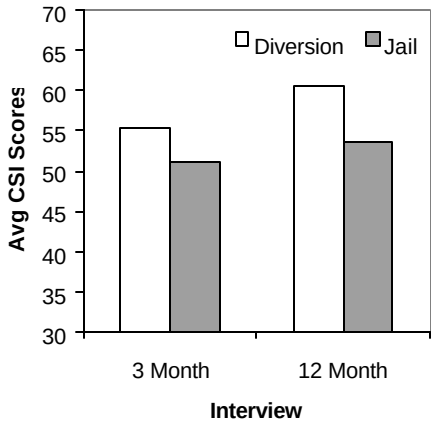


Figure 5. Differences between diversion and jail groups in the percentage of participants who reported using the emergency room for mental health and substance abuse problems at the 3- and 12-month interviews.

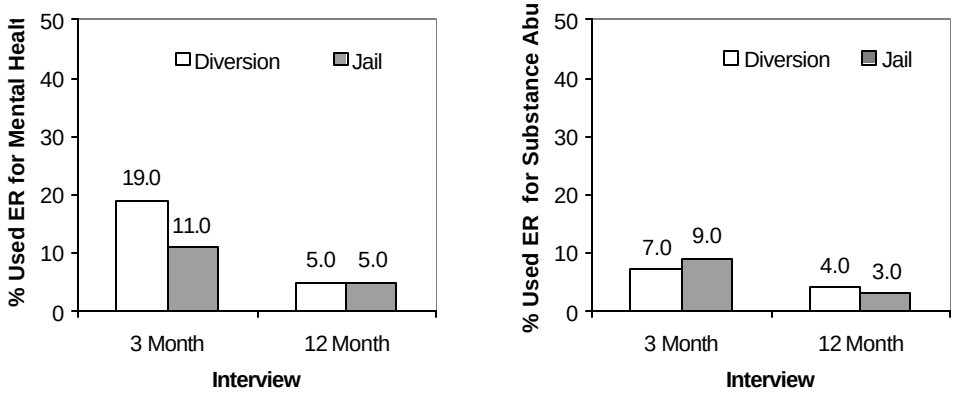


Figure 6. Differences between diversion and jail groups in the percentage of participants who reported receiving inpatient treatment for mental health and substance abuse problems at the 3- and 12-month interviews.

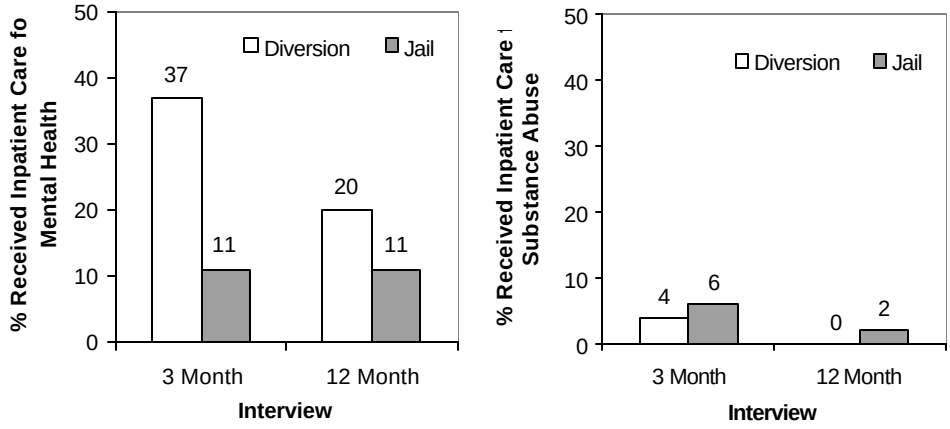


Figure 7. Differences between diversion and jail groups in the percentage of participants who reported receiving outpatient counseling for mental health and substance abuse problems at the 3- and 12-month interviews.

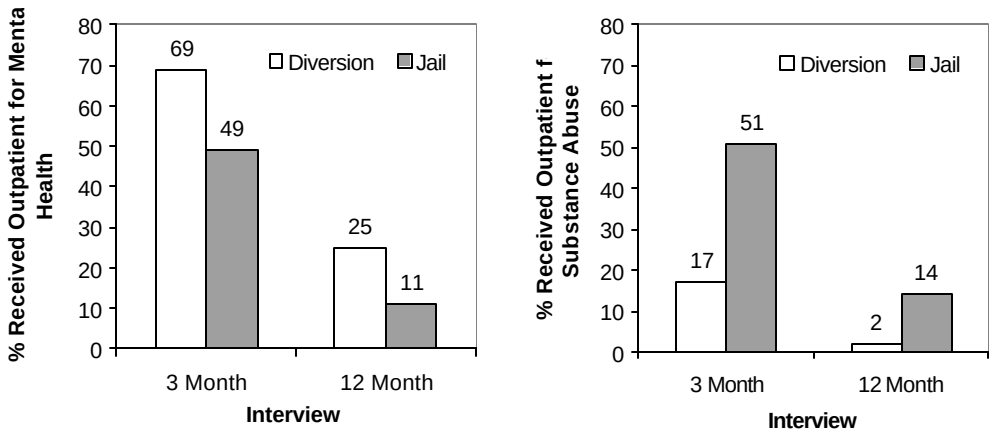
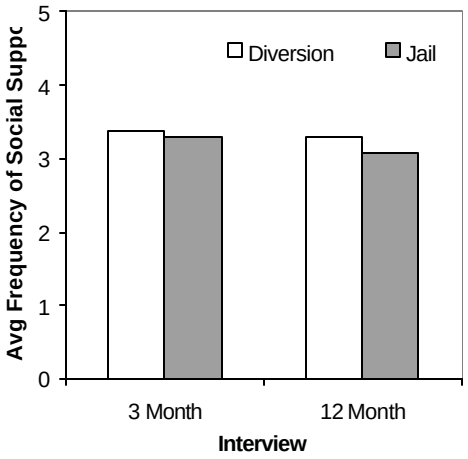


Figure 8. Differences between diversion and jail groups on frequency of social support at 3- and 12-month interviews.



Appendix G:

Multnomah County Criminal Justice Diversion Program: History of Systems Chart

The History of Systems Relating to the Multnomah County Criminal Justice Diversion Program

Year	Criminal Justice Community Milestones	Oregon Managed Care Milestones	CJDP Milestones	Multnomah County MH System Milestones	Multnomah County substance abuse treatment System Milestones	Impact/Outcomes[i]
1982	Multnomah County developed/designed high-rise direct supervision facilities.			Funding intended to reduce state mental hospital bed utilization approved for mental health projects in Multnomah County.		
1983				Legislature adopted plan for counties to assume responsibility for state hospital beds, plan for restructuring state hospitals, and establishes community treatment and community crisis services.		
1984	Bud Clark elected mayor and seeds of community policing philosophy began to take form at PPB.					
1985-1986	1986 - Portland City ordinance was passed requiring new convenience stores that would be open more than 18 hours/day to meet with the community about security concerns and prepare a "good neighbor" plan outlining how they would deal with these issues			OADAP separated from Mental Health Division. Mental Health Division Task Force on Civil Commitment of Mentally Ill Persons makes recommendations and a "Critical Mass" survey of the counties is completed.		Neighborhood Associations found the "good neighbor" plans and the process useful. ONA eventually generalized the process to create a framework for dealing with any neighborhood problem.
1987	Overlook Neighborhood residents held forum over prostitution in their neighborhood – began discussions of community policing strategies			Civil commitment laws substantially revised. Private mental health and drug and alcohol treatment programs allowed to receive third party insurance payments.		

Year	Criminal Justice Community Milestones	Oregon Managed Care Milestones	CJDP Milestones	Multnomah County MH System Milestones	Multnomah County substance abuse treatment System Milestones	Impact/Outcomes[1]
1988	Citizens in Multnomah County decided to expand Jail space within the county through a levy			Report to Governor Goldschmidt on Improving the Quality of Oregon's Psychiatric Inpatient Services recommended the division of most acute care patients from adult psychiatric wards by 1995.		Citizen's decision to expand jail space led to the design and development of the first "county level" direct supervision dormitory facility at Multnomah County Inverness Jail (each dorm 50 inmates)
1988-1995				Local acute care facilities developed, mostly through contracts with psychiatric units in community hospitals. (111 beds)		
1989		Oregon Health Plan approved by Legislature.		Civil commitment laws further revised. Mental Health Division renamed to Mental Health and Developmental Disability Services Division.		
1990	January – Portland City Council officially adopts the Transition Plan proposed by PPB to create bureau-wide approach of community policing Neighborhood Liaison Program (NLP) established[1] Chief Potter is sworn in "Rocket Docket" used to eliminate backlog of PCS cases					(Data for 1990-1991) Enrollment in outpatient substance abuse treatment begins to increase Number of treatment episodes per person begins to increase
1991	Byrne and local city funds utilized Citizens decide through levy vote to expand Multnomah County Inverness Jail – 5 new			1991-1993 Three innovative projects were developed: consumer-operated case management services; two joint ventures between MHDDSD and Vocational Rehab. Division to provide job training for persons with mental illness; and 65		BJA funds matched with city and county funds

[1] This program began in North Precinct with designated parole officers assigned to certain Neighborhood Associations with responsibility of attending their meetings and helping coordinate a response to their concerns. NLP now bureau-wide and 95 officially recognized Neighborhood Associations.

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	housing areas are added			individualized discharge plans with special supports to meet needs of long-term patients.		
1992	Ordinance for Drug Free Zones is passed				Residential beds set aside for drug court clients	Reported alcohol use begins to decline while reported opiate use begins to increase (1992-1993)
1993	Drug Free Zone ordinance modified to include arrest for possession			Rights of individuals receiving mental health and developmental disabilities services from state-authorized or state-supported programs or facilities established. Civil commitment laws revised.	Portland Target Cities Project start date State begins more careful monitoring of patient care (-1996)	Goals: increase access, effectiveness, foster coordination among treatment providers and other related agencies, continually increase system self-improvement Reported outpatient length of stay drops, possible due to more accurate reporting by clinicians CPMS reporting becomes more thorough Oregon Administrative Rules enhance quality of system Increase in SA treatment service utilization (1993-1994)
1994	Drug Free Zones modified, one zone eliminated, and attempt crimes added, zone size limits eliminated President Clinton signs the Violent Crime Control and Law Enforcement Act of 1994	The Health Care Financing Administration provided Medicaid waiver	1994-1995 Multnomah County Work Group on Police and Crisis Services supports the local adoption and implementation of the "Memphis-model" crisis intervention team. Work Group recommends that training on issues	Extended Care Management Unit established by Emergency Board to assure coordination of adult-long term care services.	IJIP (In Jail Intervention Program) begins	Percent of women in substance abuse treatment increases Reported heroin use increases (1994-1995) This enabled the state to expand coverage to all adults and their dependents whose income ell below the federal poverty limit (more than doubling the

[2] 9-1-1 dispatchers, judges, prosecutors, defense counsel, alcohol and drug treatment providers, EMT's, Jail Staff, Firefighters, Oregonian police reporter, Parole/probation officers and pre-trial release staff, Exceptional needs care coordinators (for OHP)

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			specific to individuals who are mentally ill, developmentally disabled, and/or those who abuse alcohol or drugs should be provided to other groups.[2] Work Group supports the creation of a centralized crisis triage center to serve individuals with chronic mental illness, dual diagnosis individuals, and children.			current eligible population) Creates competition among SA treatment providers Treatment program funded by PTCP
1995	Legislature gave the State Department of Corrections responsibility for developing and providing a full range of mental health services for inmates in correctional facilities. Dan Noelle elected Multnomah County Sheriff Oregon voters pass Measure 11 – increased prison time for violent crimes, sending more people to state prisons for a longer time. ORS SB 1145 creates local public safety coordinating councils Mult. Co. Board of Commissioners supports SB 1145 passing an ordinance establishing the Local Public Safety	Managed care instituted, OHP now covers individuals 100% below poverty line (approx. 13 insurance companies providing coverage to OHP recipients)		1993-1995 124 additional slots (PASSAGES Projects) were developed as an extension of the successful “365” projects. 1995 Mental Health Task Force created by HB3445 to study and make recommendations in specified areas. Phase-in of integration of mental health services into Oregon Health Plan extended to 1997.	Portland Target Cities Project Central Intake begins (-1998) OR adopts benchmark diagnosis and level of care recommendations Capitated chemical dependency benefit added	Increased communication among providers, contributed to the standardization of access to SA treatment, improved access to SA treatment in the jails, likely contributor to the deterioration in completion rates for residential and CIRT programs, and to maintaining completion rates at Hooper Detox Cost shifting and case shifting Central intake receives unwanted clients Increase in competition among providers Increase in types of services available to clients, increase in access to substance abuse treatment Administrative costs increase for providers

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	Coordinating Council (LPSCC) of Mult. Co. Multnomah County awarded crime bill $ for drug court Eligibility criteria are modified, probationers and parolees now eligible USDOJ awards $512,055 Enhancement grant					Providers forced to serve more clients to continue funding at current levels "Unbundling of funding streams" for substance abuse treatment The goal of this was to improve the integration of substance abuse treatment with physical health care Measure 11 – led to creation of lpscc to help communities cope with offenders locally
1996	Report published on Profile of Psychiatric Alert Inmates Booked in Multnomah County Justice Center During 1995 – shows drastic yearly increase of inmates with psychiatric alerts Decision made to increase all dorms at MCIJ to 55 inmates pushing the limits of the square footage and associated support services. Drug Court: * Policies are modified, more restrictive time limits for completion of Phase I, for payment of fees, and for treatment * DA expands eligibility criteria *Probationer/parolees excluded from Drug Court			1996-1997 In 20 "demonstration" counties, provision of Medicaid-covered outpatient and acute inpatient services were contracted through managed care organizations under OHP. For individuals ineligible for Medicaid, Community Mental Health Programs continued to deliver mental health services prioritized according to statutorily mandated criteria based on risk of hospitalization and dangerousness.	Methadone program restructured Finigan's 1996 study around costs and benefits of alcohol and drug treatment in Oregon shows $5.60 in total savings per $1.00 spent on alcohol and drug treatment.	Previous failures are eligible, new charges can become convictions, with no custody units, and participant remains in program, quantity restrictions expanded Counseling and health services departments created, MIS, integrated MH and SA treatment offered

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	Measure 50 passes (limiting property tax increases to 3% reducing county funds)					
1997	Probationers/parolees included in Drug Court DA Expedited Plea (X-Plea) program for drug cases begins Drug Court Docket expands to 5 days/week Report from Public Safety Coordinating Council (Work Group on the Mental Health Treatment Needs of Offenders)		CTC created to diagnose substance abuse and mental health Criminal Justice Diversion Program begins (-2001) Relationship of mental health and substance abuse becoming more important	Oregon lawmaker's expanded Medicaid eligibility criteria twice since OHP's inception, increasing the number of Oregonians eligible for Medicaid approximately 80%.	Criminal Justice Diversion Program begins (-2001) Relationship of MH and SA becoming more important	Enrollment in outpatient treatment doubles since 1988 (1997-1998) Expedited plea does not appear to affect drug court participation
1998	MCIJ begins 18 month expansion				County redistribution of MH funding Portland Target Cities Project ends	
1999	MCIJ completes expansion with an additional 420 beds and total capacity at 977. MCIJ also completes Administrative Support Center.			December: Preliminary report to the Board of County Commissioners from the Mult. Co. Mental Health Task Force (MCMHTF) presented a "map" of the mental health system's dynamics and dilemmas	OADAP initiates "Track B"	MC receives lump sum from state based on projected case rate and is responsible for monitoring providers for the state, county performance standard have yet to be operationalized
2000	New special courts are emerging: domestic violence courts, property crimes with PCS courts, and mental health courts June 30: IJIP ended July 16: Carol Nykerk promoted to Program Manager September 12: Most counselors relocated into new teams October 5: Started teaching groups to entire MCIJ			March: MCMHTF issued a report to the Mult. Co. Board of Commissioners identifying significant problems with the County's mental health system and made recommendations for an overhaul of the system. March: MCMHTF Workgroup on Cost Effective Continuum of Care Report to the Board of County Commissioners.hk May: Board of County Commissioners passed Resolution 00-063 creating a Mental Health Design Team to work with county, state, and community personnel to develop short and long term action	Drug Courts and Medicaid Managed Behavioral Health Care study begins (-2003) OR increased residential bed reimbursement rate for providers LPSCC's Report on alcohol and drug treatment and criminal justice roughly estimates that only about 1/3 of current need for treatment is being met. It also reports that criminal justice accounts for almost ½ of the enrollments in publicly funded alcohol and drug treatment.	Approximately 2 insurance companies providing coverage for OHP recipients Focus on women with children as recipients of substance abuse treatment services Providers receive closer to what it actually costs them to provide this service

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				plans to improve Mult. Co. mental health services. September: Board of County Commissioners passed Resolution 00-161 adopting a vision statement for a consumer and family-centered mental health system based on the recommendations of the Design Team.		
2001	Drug Court Eligibility expands: PCS I, II, attempt PCS I, II, Tampering with drug records charges, no other associated or pending charges permitted, no current participants, no DUII, no other holds January: Reorganized counselors by functions into four teams February: Teach groups to entire MCIJ from new teams		August 1: CTC Closes and Officers are directed to bring individuals to the geographically closest emergency departments	Initial Draft Report Mental Health System Redesign – An Action Plan for Multnomah County – Phase I presented to the Mental Health Coordinating Council August 1: CTC Closes and Officers are directed to bring individuals to the geographically closest emergency departments		The closure of the CTC leaves Multnomah County without a secure evaluation unit

Funding

before managed care: slot dollars (typically 50-60% of actual cost to provide services), supplemented by Medicaid and private insurance/private pay, after managed care: OHP covered clients below 100% of poverty, no more additional funding for "slots" (which typically covered the working poor), and private insurance/private pay after Track B: OHP still covers 100% of poverty or lower, slot dollars cover working poor and private pay with sliding scales to make up the rest

Average Length Of Stay (Outpatient)
Was decreasing before OHP, has stabilized since OHP was established

Notes from:
Interviews with Valerie Moore, InAct, Jim Peterson and Philip Windell, Multnomah County Behavioral Health
10 Year trends 1988-1998, Multnomah County's publicly funded and regulated alcohol and drug treatment system
Access to substance abuse treatment services under OHP, Deck, et. al.
Implementation of Portland Target City Project and Its Effects on Multnomah County's Publicly Funded and Managed Substance abuse treatment System
The Effects of Portland Target City Project on the Alcohol and Drug Treatment Community Managed by Multnomah County's Department of Community and Family Services

[i] Unless otherwise noted, data from State Client Process Monitoring System (CPMS) and Multnomah County's Department of Community Justice's contract monitoring system, Windell, Phillip, 10 Year Trends…